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ABSTRACT

Challenges inherent in providing AIDS/HIV education programs to reduce student involvement in behaviors that place them at risk are examined in this bulletin. Chapter 1 highlights some of the limitations of many existing programs and offers strategies for strengthening educational efforts. Chapter 2 explores some of the factors that affect whether students' knowledge of AIDS/HIV will have an impact on their attitudes and behaviors. Finally, some general guidelines are offered in chapter 3 to help educators determine what kind of information students may be ready to cope with at various ages. Two statistical tables and a bibliography listing 51 references are included. (LMI)

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HIV/AIDS EDUCATION

The Challenge of Reducing High-Risk Behaviors

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Preface

There is no question that adolescents are at risk of becoming infected with HIV. To begin with, a large number of teens are sexually active. For example, a random survey of 2,046 Oregon high school students conducted during the 1989-90 academic year found that 51 percent of students reported that they have had sexual intercourse. Furthermore, a large percentage of sexually active adolescents don't practice any form of contraception. Of those who do, only a minority use condoms, the most effective method of preventing HIV transmission among people who are sexually active.

Another factor that increases one's risk of HIV infection, sharing needles during IV drug use, is also a problem for some youth. In a recent national survey of HIV-related knowledge and behaviors among U.S. high school students, Oregon students reported the highest rate of IV drug use—5.4 percent—among participating states. In addition, the widespread use of other drugs among students can raise their risk of HIV infection by impairing their ability to make sound decisions, including sexual decisions.

All these factors underscore the vital need to provide students with both information and skills necessary to protect themselves against HIV infection. Therefore, this Bulletin examines some of the challenges inherent in providing education programs that move beyond increasing students' knowledge about HIV and AIDS, which is already at a fairly high level, and strive to reduce student involvement in behaviors that place them at risk.

Lumsden is associate editor for OSSC. She has a bachelor's degree in journalism and a master's degree in counseling psychology from the University of Oregon.

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Introduction

Acquired Immune Deficiency Syndrome, or AIDS, is a disease for which no vaccine has been developed and no cure has been found. While researchers try to develop medical means of combatting the disease, people continue to die. Some of those who are dying are young people. In fact, one in every five cases of AIDS occurs among twenty- to twenty-nine-year-olds. Teens are being infected, but the long incubation period—sometimes eight years or more (Katherine Fraser 1989)—between infection with HIV and the appearance of AIDS symptoms may cause teens to doubt whether they are really at risk. The fact is that teens are indeed vulnerable, yet someone who becomes infected with HIV during their teenage years may remain asymptomatic until their mid- to late-twenties.

Until significant medical breakthroughs occur, education is the primary defense we have against AIDS. Parents and educators alike have a responsibility to inform young people about behaviors that place them at increased risk of becoming infected with HIV, the virus that causes AIDS. Educational efforts should not only strive to increase awareness of the disease and motivate youth to avoid high risk behaviors, but also address fear of and prejudice toward those who are infected.

Because our nation's 90,000 elementary and secondary schools serve approximately forty-seven million students annually, they are well-positioned to help young people become informed about the nature of the AIDS epidemic and behaviors that can reduce one's risk of infection, in much the same way that they help students to gain awareness of other health-related topics.

However, HIV/AIDS education efforts must have an impact that extends beyond the cognitive realm. It is not sufficient to show that students' scores on tests about HIV/AIDS improve following instruction. If the knowledge is not applied on a personal level, that is, if it does not affect the level of student participation in high-risk behaviors, little has been accomplished.

The issue of HIV/AIDS is more complex and more controversial than most other health-related topics about which schools educate youth. People may not see eye to eye when it comes to such questions as what should be taught, how programs should be funded, who should provide instruction, and who should receive instruction. The National School Boards Association publication *Reducing the Risk* (Kathleen McCormick 1989) emphasizes that although HIV/AIDS is "first and foremost" a medical problem, "it entails a host of other problems—social, moral, ethical, legal, fiscal—with numerous and complex implications for the entire community, including schools." A recent publication of the Association of California School Administrators (1989a) identifies some of the specific challenges that HIV/AIDS presents for educators:

> Educators must weigh the rights of students with AIDS against parental concerns for safety. They must develop AIDS curricula that deal with explicit information some parents and groups find offensive. They must combat the feelings of invulnerability many students have so that students may learn the role of responsibility and choice in the prevention of AIDS. And, they must spread compassion, not fear.

Although many districts around the country have already implemented some form of HIV/AIDS education, there is evidence that, generally, the quality of existing programs leaves much to be desired. According to Diane Allensworth and Cynthia Symons (1989), those responsible for designing or administering HIV/AIDS education programs "frequently gravitate toward emotionally based or 'band-aid' reactive approaches to the problem." Similarly, the Report of the President's Commission on the Human Immunodeficiency Virus Epidemic characterizes the efforts of many schools as "a piecemeal, fractured, and largely ineffective approach" (1988).

Judy Olson laments that once districts offer some form of HIV/AIDS education, their interest in this area begins to wane and they tend to adopt the attitude that "we've already done it, i.e., adopted policies, implemented an instructional program, trained staff in infection control procedures" (Washington Association of School Administrators 1989).

Oregon is among the states that mandate K-12 HIV/AIDS education. Although Oregon schools may be in compliance with state directives regarding HIV/AIDS instruction, this Bulletin challenges school leaders and educators to review their programs and, if needed, to upgrade their initial efforts in this crucial area.

Chapter 1 highlights some of the weaknesses that have been found in many existing programs and offers strategies for strengthening educational efforts. Chapter 2 explores some of the factors that affect whether students' knowledge of HIV/AIDS will have an impact on their attitudes and behav-

ioral choices. Finally, some general guidelines are offered in chapter 3 to help educators determine what kind of information students may be ready to cope with at various ages.

Chapter 1

Strategies to Strengthen HIV/AIDS Education

"It is important for districts that have begun HIV/AIDS education programs to resist the temptation to become complacent. Instead of being satisfied with efforts that merely comply with state directives or quell the voices of constituents who have been clamoring for them to "do something," most districts need to strengthen their initial attempts at tackling this complex issue.

As the NSBA publication *AIDS Education—More To Be Done?* (Brenda Greene 1990) emphasizes,

> Effective HIV/AIDS education takes a comprehensive approach, putting its mark not only on policy and curriculum but on teacher training, community involvement, program evaluation, and ongoing policy review. Sound policy development, undoubtedly, is the first stroke. But without a commitment to planned implementation and ongoing feedback, HIV/AIDS education will resemble an unfinished portrait.

In the publication *Guidelines for Effective School Health Education to Prevent the Spread of AIDS*, the Centers for Disease Control (CDC) offers nine assessment criteria that can be used by administrators and school board members to determine the extent to which their programs are providing effective HIV/AIDS-related education:

1. To what extent are parents, teachers, students, and appropriate community representatives involved in developing, implementing, and assessing AIDS education policies and programs?
2. To what extent is the program included as an important part of a more comprehensive school health education program?

3. To what extent is the program taught by regular classroom teachers in elementary grades and by qualified health education teachers or other similarly trained personnel in secondary grades?
4. To what extent is the program designed to help students acquire essential knowledge to prevent HIV infection at each appropriate grade?
5. To what extent does the program describe the benefits of abstinence for young people and mutually monogamous relationships within the context of marriage for adults?
6. To what extent is the program designed to help teenage students avoid specific types of behavior that increase the risk of becoming infected with HIV?
7. To what extent is adequate training about AIDS provided for school administrators, teachers, nurses, and counselors—especially those who teach about AIDS?
8. To what extent are sufficient program development time, classroom time, and educational materials provided for education about AIDS?
9. To what extent are the processes and outcomes of AIDS education being monitored and periodically assessed?

Several of the areas touched upon in the CDC's assessment guidelines and other issues relevant to program effectiveness are explored in this chapter. First, the value of integrating HIV/AIDS education into existing health education programs is discussed. The need to put more emphasis on teacher and staff training is examined next.

Other recommendations mentioned in this chapter include working closely with community members, increasing the amount of time that is devoted to HIV instruction, ensuring that instruction continues through the upper grades, adapting prepared curricula to the needs of specific audiences, focusing on skill development and decision-making, obtaining information about the extent to which young people in a community are involved in high-risk behaviors, and engaging in formative program evaluation and self-evaluation.

Provide HIV/AIDS Education within the Context of a Comprehensive Health Education Program

According to many authors, optimally, HIV/AIDS material should be taught as part of a larger health-oriented curriculum that begins in kindergarten and extends through grade 12. For example, in its guidelines the CDC notes, "Education about AIDS may be most appropriate and effective when carried out within a more comprehensive school health education program

that establishes a foundation for understanding the relationships between personal behavior and health." The President's Commission on HIV also advocates "the introduction of an age-appropriate comprehensive health education curriculum that encompasses grades K-12," noting that movement in this direction is "long overdue."

Because of the urgency of providing youth with information about HIV and AIDS, some school districts have been presenting HIV/AIDS education in isolation from other subject areas. Educating young people about HIV/AIDS in a less than ideal manner is preferable to withholding crucial information until better conditions exist. However, most authors agree that this way of proceeding should only be used as a temporary, stop-gap measure.

In 1988, in an address to the "Conference on AIDS Education in the Schools," Mary Futrell, then president of the National Education Association, stressed the need for HIV/AIDS education to be incorporated into a comprehensive health education context. Futrell noted the following needs in the area of school health education:

> We need schools that offer models of how to make health education one of the basics in the school's curriculum. In many schools, we have programs like writing across the curriculum. I would like to see schools in which we have health education across the curriculum. One of the things we need to look at in teacher preparation is developing a large health education component. A knowledge and understanding of culturally sensitive health care issues should be part of the professional preparation of every teacher.

Saying that a comprehensive health education program offers the most fertile soil for HIV/AIDS education is one thing; attempting to comply with this recommendation is quite another. Many, if not most, districts do not have an existing health education program within which to weave HIV/AIDS information. In fact, only twenty-five states require health education for high school graduation (Dianne L. Kerr 1989).

Although the term surfaces frequently in articles about HIV/AIDS education, there may be some confusion about exactly what is meant by *comprehensive school health education*. To shed some light on the scope of the term, Kerr offers the definition embraced by the National Professional School Health Education Organizations. She states that it consists of

> health education in a school setting that is planned and carried out with the purpose of maintaining, reinforcing, or enhancing the health, health-related skills, and health attitudes and practices of children and youth.

Kerr goes on to state that comprehensive health education programs involve three interdependent strands—health education or instruction, health

services, and healthful school environment. Parents and community members, as well as students and teachers, are typically involved in the planning, implementation, and evaluation of such programs, according to Kerr.

The instructional component of a comprehensive health education program should include

- instruction intended to motivate health maintenance and promote wellness and not merely the prevention of disease and disability
- Activities designed to develop decision-making competencies related to health and health behavior
- A planned, sequential pre-K to 12 curriculum based on students' needs and current and emerging health concepts and societal issues
- Opportunities for all students to develop and demonstrate health-related knowledge, attitudes, and practices
- Integration of the physical, mental, emotional, and societal dimensions of health in the following content areas—community health, consumer health, environmental health, family life and human sexuality, growth and development, nutritional health, personal health, prevention and control of disease and disorders, safety and accident prevention, and substance use and abuse (Kerr)

Debra Haffner (1988) also recommends integrating AIDS education into existing comprehensive health or sexuality education programs. Within this context, she suggests that educators may want to provide HIV prevention information during discussion of topics such as "self-esteem, family and personal values, decision-making, communication skills, drug abuse prevention, STDs, and peer pressure." Like other authors, Haffner emphasizes the need for developing healthy attitudes and behavioral skills in students, rather than limiting the educational process to merely enlarging students' knowledge base about HIV/AIDS.

Whenever HIV/AIDS-related issues are raised formally during an instructional unit or arise spontaneously in the classroom, it is essential for instructors to allow students to ask questions. Preventing students from expressing their concerns and inquiring about things they don't understand will seriously compromise the educational process.

Obviously, AIDS has implications for and relevance to many disciplines other than health. Because of this, HIV/AIDS-related topics are sometimes incorporated into subject areas such as biology/science, social studies, sexuality education, psychology, current events, civics/history, and ethics, in addition to health.

Increase Training for Teachers and Other School Staff

Lack of adequate teacher training is a weak link in many existing HIV/AIDS programs. A U.S. General Accounting Office examination of HIV/AIDS programs in 245 school districts found that teachers are not receiving enough instruction about AIDS and HIV (Ellen Flax 1990). In its telephone survey, the GAO found that 17 percent of teachers in the sample who were responsible for teaching about HIV/AIDS had not received any training. The GAO survey also revealed that while most teachers who are required to teach HIV/AIDS education had received some inservice training, the training "was not as extensive as districts would have liked and was far less comprehensive than what the C.D.C. recommends."

Brenda Greene (1990) considers teacher training "the most critical factor" in determining whether an HIV/AIDS education program is effective or ineffective. Teachers not only have to be knowledgeable about the biomedical aspects of HIV transmission and AIDS, but must "be prepared with strategies to address students' attitudes, beliefs, and skills—if behavior is to be influenced."

Financial Considerations

Inservice training can be expensive. In many instances, while regular teachers are receiving training, substitute teachers must be paid to cover their classes. If training occurs outside school hours, teachers must be compensated for the extra hours. Hiring a consultant to develop and implement a training program for teachers can be effective, but this, too, is costly, notes Greene.

Videotapes on instructional methods and teleconferencing via satellite dish are mentioned by Greene as ways of reducing the cost but not necessarily the quality of teacher training. Another cost-cutting option noted by Greene is teacher self-education, in which teachers are provided with high quality written materials about HIV/AIDS. While self-education has value, Greene says that learning in isolation is less effective than interactive learning formats.

Some schools are creating a resource file that contains information about HIV/AIDS education. And Greene mentions that some schools may want to publish an inhouse HIV/AIDS education newsletter that "adapts general advice and tips to the special needs of schools."

Each district should publicize the name and phone number of the person who functions as its HIV/AIDS education coordinator to ensure that all teachers are aware of whom they can consult. In districts that have an electronic mail system, Greene suggests this as a viable way of disseminating HIV/AIDS information to teachers if they are able to access the information

through conveniently located computer terminals.

In addition to educating teachers, schools should provide other staff members with information about HIV/AIDS. Coaches, counselors, activity advisors, and other nonteaching staff should be equipped to reinforce what is taught in the classroom.

Finally, since information about HIV/AIDS is changing so rapidly, it is critical for the person responsible for training district personnel to undergo periodic training, thereby ensuring that out-of-date information is not passed on to others. Districts can find out about training opportunities for trainers by contacting their state education agency (every state has an HIV/AIDS education coordinator), their state school boards association, or the local chapter of the American Red Cross.

Show Respect for Teachers' and Students' Attitudes

School leaders should be aware that there may be a small minority of teachers who, despite receiving adequate training, do not feel comfortable with the prospect of teaching about HIV/AIDS. When this is the case, it is prudent to allow them to decline, since students will probably sense these teachers' discomfort. "They are likely to convey their fears to the students, give a mixed message, and inhibit students from asking questions," notes Fraser (1989).

Training of school personnel must not be limited to providing up-to-date information about HIV and AIDS that is based on reliable medical evidence. It is also imperative for teacher training programs to help teachers explore their AIDS-related attitudes and values.

Some students have parents or other family members who are homosexual or who use illegal intravenous drugs. Teachers should keep this in mind when they discuss sexual practices and IV drug use. Unless information in these areas is presented in a nonjudgmental manner, in addition to having fears about their loved ones contracting AIDS, these students may experience unnecessary guilt and shame (Jeffrey Black and Lorraine Jones 1988).

Preferences of Adult Learners

When administrators decide to provide initial teacher training or supplemental training, they need to determine how to effectively convey information about HIV/AIDS. In *The AIDS Crisis: Guidelines for School Districts* (WASA 1989), Judy Olson identifies several things those teaching teachers and other adult learners may want to keep in mind:

> Adults are more vulnerable as learners than are students in our schools. They are more uncomfortable when they don't know some-

> thing and when the thing they don't know is perceived as potentially dangerous, they can be quite defensive. They also need to have their previous knowledge and expertise validated.

Olson believes that adults learn most easily when they are in an interactive learning environment. "They need a chance to discuss, talk, move around; but in a safe environment," notes Olson. Although adults process information most easily when they are in an interactive environment, initially many adults are reluctant to participate in discussions. Therefore, before attempting to engage adults in larger group discussion, it is advisable to involve them in exercises with a single partner. Once they feel comfortable discussing the material with one other person, they will be more at ease when asked to become part of a larger group.

To accommodate people with different learning style preferences, a variety of methods should be used to present the information. "Some adults process information most accurately when it is spoken, others need pictures, and still others must manipulate items to best process," notes Olson. To maximize adults' information processing, therefore, Olson recommends that presenters "tell the participants about the information, show them pictures that represent the information, and involve the participants in the information in a meaningful way." She also suggests providing handouts that contain blank areas participants can use for notetaking.

In addition to presenting material in a variety of ways, information should be broken down into "chunks." This heightens participants' ability to grasp and retain the material. Presenters should not speak for longer than twenty minutes without actively engaging participants. Metaphors can also help to fix the material in participants' minds.

Other Strategies

In addition to integrating HIV/AIDS instruction into a comprehensive health education program and providing more and better teacher training, attention to a number of other areas may strengthen district efforts to educate students about HIV/AIDS.

Devote More Time to HIV/AIDS Instruction

According to Allensworth and Symons (1989), "Research has demonstrated that 40-50 hours of instruction is necessary for health behavior change to occur." These authors note that there is a great discrepancy between the amount of time devoted to instruction about HIV/AIDS that occurs in schools and the amount that is necessary to produce behavior change. "More time must be invested in AIDS education," state Allensworth and Symons, "if

health-enhancing behaviors are to be adopted because behavior change increases in direct proportion to the amount of instruction."

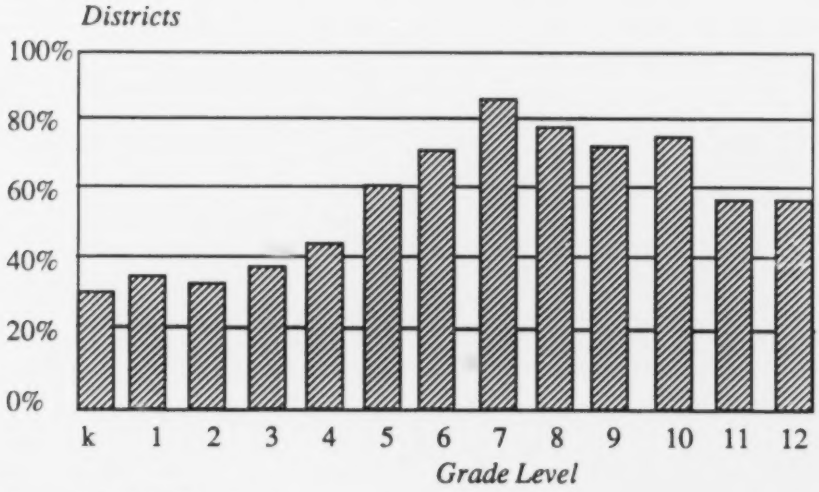
Provide Instruction in a Timely Manner

Recent reports published by the U.S. General Accounting Office found that although two-thirds of the districts surveyed offered at least some HIV/AIDS instruction, only 5 percent provided instruction at every grade level, which is what the CDC recommends.

A GAO survey (Flax 1990) also found that students may not be receiving HIV/AIDS instruction during optimal times. Surprisingly, seventh-grade students in the sample were five times as likely to receive AIDS education as were eleventh- and twelfth-grade students, despite the fact that a greater proportion of students in eleventh and twelfth grade are sexually active.

The NSBA (1990) found a similar trend among the 332 districts that participated in its HIV prevention education survey. As shown in table 1, required HIV education generally increases from kindergarten through grade 7 and then begins to decline. In urban and large/suburban districts, however, instruction does not usually decline until grade 11.

Table 1
Grades in Which HIV Education Is Required



Source: NSBA 1990.

Provide Decision-Making and Skill Development Opportunities

In addition to the amount of time devoted to HIV/AIDS instruction, the quality of instruction, of course, also affects the likelihood that behavior change will occur. To be effective, instruction must provide "learning activities in the cognitive, affective, and behavioral domains, to attend to Bloom's taxonomy of the hierarchy of learning, and to respond to the heterogeneous nature of public school populations" (Allensworth and Symons). Unfortunately, much instruction in the schools is primarily cognitively based and concentrates heavily on recognition and comprehension, while application and synthesis are often neglected entirely or given only minimal attention.

Instructional goals should encompass a number of areas, "from raising consciousness and increasing knowledge, which are fundamental to the decision-making process, to applying decision-making principles in the context of personal behavior management and social action," state Allensworth and Symons. It is not enough to merely increase students' information about HIV/AIDS. "Instructional goals," they state, "also must include skill development as a means to decision-making, behavior change, and social action. The complexity of the AIDS issue dictates that AIDS programmers move beyond didactic instruction and develop refusal, assertiveness, peer pressure management, communication, decision-making, and esteem enhancement skills."

Helping students to develop clear communication skills has the potential to positively affect many areas of students' lives. David and Beverlie Sloane (1990) point out that good communication can lead to better decisions about alcohol and drug use; to an increased ability to cope with the obstacles surrounding protection and delay; and to preventing the spread of STDs, unintended pregnancy, and HIV infection.

Adapt Prepackaged Curricula

It is also important to modify prepackaged curricula, note Allensworth and Symons. Often considerable time is spent trying to find the "right" prepackaged curriculum or textbooks. While prepared materials can serve as a base, time should be devoted to modifying such packages, tailoring them to the specific needs of the students that the material will be presented to.

Charles E. Basch (1989) agrees that HIV/AIDS programs should be adapted to specific populations. He contends that little attention has been devoted to discovering whether members of various ethnic, racial, or gender groups respond differently to information about HIV/AIDS. Identical information may have different meaning for different groups, and barriers to understanding and behavior change may also differ across groups. J.A. Flora

and C.E. Thorensen (1988) state:

> Each grouping may differ in their values, attitudes, skill and information levels, and social contexts with respect to sexually related behavior. Intervention programs must carefully consider the type of language used (e.g., formal and informal metaphors), the reading level of printed material, normative beliefs about sex and AIDS, salient characteristics of prestigious social models, and perceived meanings of sexual behaviors, along with perceived vulnerability and explanatory style.

Merely expressing concerns about AIDS or practicing safer sex is in opposition to the masculine gender roles of some ethnic and racial groups. Other minority groups have especially strong prohibitions about discussing sexual issues. Recognizing the needs of different populations, AIDSFILMS, a group based in New York City, has created several films about AIDS that are intended for specific groups of young people. Films have been made to address the unique issues faced by black, Hispanic, and female teens. Those implementing HIV/AIDS curricula should strive to be sensitive to the diverse issues faced by different subpopulations of students.

Collaborate with the Community

Schools must work together with the larger community to ensure that various messages presented in the classroom are reinforced in other parts of the community. As Allensworth and Symons note, "The significance of the relationship between schools and supportive communities must not be underestimated." These authors also remind us that the majority of learning takes place outside, not inside, classrooms. Therefore, it is particularly important that school personnel and other community leaders are united in encouraging health-enhancing behavior.

HIV/AIDS education should be a shared responsibility, not left solely to any one social institution, such as schools. Groups that can elect to participate in such educational efforts include parents, schools, churches and synagogues, community agencies, youth-serving agencies, and health organizations. If young people are hearing the same messages about AIDS through a number of different channels in the community, the messages will be more apt to be taken seriously.

Four environmental factors identified by Walberg are cited by Allensworth and Symons as consistently affecting learning. They are "the home, the classroom social group, the peer group outside of school, and use of out-of-school time (specifically those hours spent watching television)." Not only do children learn from family members, peers, and the media, but "these groups have the ability to indirectly influence motivation and responsiveness to instruction." Because of their impact on the learning process, curricula

developers should take these variables into consideration when designing instructional materials.

Obtain Data on Local Participation in High-Risk Behaviors

It is helpful to obtain data about the incidence and prevalence of risk behaviors among adolescents and identify principal determinants of these behaviors, such as knowledge and beliefs. Laura Kann and her colleagues (1989) propose administering school-based surveys of adolescent health knowledge, beliefs, and behaviors in order to accurately identify areas of greater and lesser need.

While acknowledging that "school officials legitimately are concerned about the usefulness of survey data, about the time required of administrators, faculty, and students in conducting the survey, about protecting student's privacy, and about potential concerns of parents or the community," Kann and her associates contend that effective HIV/AIDS education directed at adolescents should be guided by quantitative data on the distribution of high risk behaviors and the primary determinants of those behaviors.

Once programs have been implemented, Kann and colleagues argue that by conducting annual surveys schools can help to ensure that HIV education remains focused on decreasing those adolescent behaviors that increase the risk for HIV infection.

NSBA's HIV education survey report also revealed a lack of knowledge about rates of three risk factors in the local teen population. The survey queried districts about their awareness of teenage pregnancy rate, prevalence of sexually transmitted diseases among adolescents, and use of IV drugs by teens in their community. Table 2 displays the responses. The report noted, "When considering the relationships of these factors to conditions that also place students at risk of school failure and dropping out of school, the low level of awareness reported is alarming."

Table 2
Percentage of School Districts Aware of Adolescent Risk Factors

Risks	*All Districts*	*Urban*	*Large/ Suburban*	*Rural/ Small*
Teenage Pregnancy Rate	59%	83%	72%	51%
STDs	25%	57%	42%	15%
IV Drug Abuse	15%	26%	21%	11%

Source: NSBA 1990.

The report posits that school officials may not realize that in many cases statistics in these areas can be obtained from local health and social service agencies.

Engage in Formative Evaluation and Self-Evaluation

Basch contends that not enough time is devoted to formative evaluation while HIV/AIDS programs are in the process of being developed. And sometimes those who fund or implement programs often attempt to evaluate the program prematurely—that is, before the program has been in use long enough for feedback to be reliable.

It is also profitable for educators to engage in self-evaluation as part of the formative evaluation process, states Basch. Areas that may be examined include whether lessons are well organized, directions are clear, material is presented in several different ways when necessary, relevant examples are provided, student confidence in teacher knowledge is promoted, student expression is encouraged, extra help is provided, questions are answered thoroughly, and areas of instructor bias and discomfort are acknowledged honestly. While reliable ways of measuring the effectiveness of HIV/AIDS education continue to be perfected, schools can concentrate on strengthening areas of acknowledged weakness in existing HIV/AIDS education programs.

The following chapter takes a look at some of the factors that tend to promote the integration of information to the point that it has an impact on student attitudes and behaviors.

Chapter 2

Knowledge and Behavior Change

Unlike many content areas of the curriculum, where communicating information about a particular subject may be the primary objective, the ultimate goal of HIV/AIDS education programs must extend beyond imparting facts about the disease and how it is and is not transmitted. In addition to students' knowledge about HIV/AIDS, their attitudes, beliefs, skills, and behaviors also must be taken into consideration.

If education about HIV/AIDS does not have some impact on the attitudes and behavioral choices made by students who engage in high-risk activities, it cannot be judged effective. Approximately 50 percent of the factors contributing to the ten leading causes of death in the United States are related to unhealthy lifestyle (Allensworth and Symons). For this reason, health education must facilitate the establishment of health-enhancing practices.

Unfortunately, this is easier said than done. Albert Bandura (1990) emphasizes that there is no direct relationship between knowledge and behavior change:

> Heightened awareness and knowledge of health risks are important preconditions for self-directed change. Unfortunately, information alone does not necessarily exert much influence on refractory health-impairing habits. It has not slimmed the obese or eradicated cigarette smoking, despite its acknowledged hazard for cancer, respiratory disorders, and heart disease, nor has it made a substantial dent on nutritional patterns that create a high risk of cardiovascular disease in those who most need to change. It certainly will not make the sexually active celibate and impel intravenous drug users to renounce drugs, which are the two major transmitted modes for the AIDS virus.

A recent survey of youth in Eugene, Oregon, underscored the fact that

possessing accurate information about AIDS does not automatically lead to behavior change. A review of the survey results indicated that, "Although teens generally have a thorough biomedical understanding of the AIDS-causing human immunodeficiency virus (HIV), there is little indication that the knowledge is producing preventive behavior" (James Thalman 1988). Another random survey of 2,046 Oregon high school students—51 percent of whom reported having had sexual intercourse and 36 percent of whom said they had had sex with four or more partners—concluded that the students "know a lot about AIDS, but many of them aren't taking steps to avoid getting the disease" (*Register Guard* September 12, 1990).

A study conducted by the California Department of Education also suggests that it takes more than raising teens' level of knowledge about AIDS to bring about a reduction in at-risk behavior (Association of California School Administrators 1989). The poll indicated that 95 percent of the 8,000 students surveyed knew the AIDS virus can be transmitted by sexual intercourse and by sharing needles. However, while half of the respondents reported that they had engaged in sexual intercourse, only 8.5 percent said that they had stopped having intercourse because of the risk of becoming infected with the AIDS virus. In addition, of the students who reported being sexually active, one-third said they never used condoms, although 88 percent knew condoms could reduce their risk of contracting the virus. Another finding of concern was that 40 percent of the sexually active students, whose average age was sixteen, reported having had three or more sexual partners.

These survey results and others highlight the fact that there is not a direct relationship between knowledge of risk and risk avoidance.

A multitude of factors influence attitude formation and affect people's decisions to alter or persist in certain behavior. Although it is probably impossible to tease out all the variables that may contribute to people's decisions to continue or discontinue particular behaviors, at least some of these factors can be identified.

Perceived Self-Efficacy

To achieve self-directed change, people need more than good, logical reasons for changing their behavior. In addition to requisite coping skills, Bandura says that people need to possess a strong belief in their ability to exercise personal control over situations.

According to Bandura, a person's perceived self-efficacy is related to beliefs about whether they can exert control over their motivation, behavior, and social environment. He contends that people's beliefs about their abilities affect such variables as "what they choose to do, how much effort they

mobilize, how long they will persevere in the face of difficulties, whether they engage in self-debilitating or self-encouraging thought patterns, and the amount of stress and depression they experience in taxing situations."

People who have a weak sense of self-efficacy are often unable to use relevant coping skills they have learned when they are faced with difficult, emotionally laden situations. Bandura asserts that "self-inefficacious thinking creates discrepancies between knowledge and action."

In a longitudinal study of psychological factors associated with sexual risk-taking behavior among gay men (L. McKusick and others 1986), perceived self-efficacy played a key role in predicting behavior. According to Bandura, "perceived self-efficacy emerged as the best predictor of sexual risk-taking behavior. The lower the perceived self-efficacy, the higher the likelihood of engagement in sexual practices that carry a high risk of AIDS infection."

Interpersonal Communication Skills

In the study mentioned above, having necessary social skills was also found to be predictive of lower-risk sexual practices. Modeling and role playing can be used to help people develop or improve interpersonal communication skills and social strategies. Training in verbal self-assertion techniques also can be effective. Guided practice in situations that approximate real-life encounters have the potential not only to help people develop competence in the use of skills relevant to these kinds of situations, but also to strengthen people's beliefs in their abilities. Students can benefit from practicing preventative behaviors, including verbal and nonverbal skills, during role plays, simulations, and other kinds of exercises that allow them to rehearse how they could choose to respond when in the midst of a similar situation that is real. The act of exercising control—either in simulated or actual situations—can help to increase perceived self-efficacy.

Students who have not had sexual intercourse and want to delay this experience need support and need skills to help them to "stick to their decision and communicate their position" (Sloane and Sloane). They also need to be aware that use of alcohol and other drugs can interfere with their ability to make sound decisions in the area of sexual behavior. In addition, students must have a sufficiently strong sense of self-esteem to assert themselves when they feel pressure from others who are sexually active.

Those students who choose to be sexually active must be helped to assume the responsibilities that accompany this choice. While some sexually active students may see a return to abstinence as a viable option, many will not. Students who make the decision to remain sexually active need informa-

tion about condoms, spermicides, and other safer sex practices.

Both sexually active students and students who are not sexually active need to be provided with opportunities to develop various communication skills that can be utilized in sexual situations. Students who want to wait can benefit from practicing refusal skills and clearly expressing their choice, while those who are sexually active need to become comfortable openly discussing issues such as AIDS and unprotected intercourse.

Developing interpersonal skills such as how to effectively resist pressure to have sex or to use illegal drugs through the use of role playing is also mentioned by Douglas Longshore (1990). He tells of a shelter for homeless teens that conducts "fishbowl" exercises in which two young people role-play pressure and resistance scenarios before a group of their peers. Following each role play, those who observed it comment on the strategies used by the two members, and a facilitator suggests additional ways of handling the situation effectively. Constructive feedback can increase the level of learning that is possible during role plays.

Defense Mechanisms

According to Janie Hall (1989), some authors "suggest that the lack of knowledge about sexual matters among young people, even after instruction, may be related to their use of denial in an anxiety-laden area." These authors emphasize the importance of addressing this denial by using desensitization techniques to reduce anxiety among teens in sex education courses, while Susan Levy (1988) stresses the need for teachers to deal with their own discomfort.

Mark Hochhauser (1988) presents a similar viewpoint, noting that

> AIDS educational materials have stressed the technical information regarding transmission of the virus, and listed the "don'ts," as if behavior change will naturally and easily follow such warnings. Yet, psychological research suggests that messages with too much fear can lead to avoidance of the message . . . . Messages emphasizing death and fear, while technically accurate, may be counterproductive, if such fear leads to psychological avoidance.

Bandura notes that in a study done by K.H. Beck and A.K. Lund (1981) fear arousal "had little effect" on whether patients followed recommended preventive behavior. These researchers studied the relative persuasiveness of health messages by varying what a person was told regarding a disease's seriousness and their degree of risk. In contrast to the impotence of fear-related messages, patients' belief in their ability to adhere to designated preventive behaviors was found to be a good predictor of whether they

actually adopted the preventive practices.

Jim Clay, youth program director for the Willamette AIDS Council, in Eugene, Oregon, tends to shy away from mentioning death when trying to reach youth with information about AIDS. In a brochure the Willamette AIDS Council recently developed for young people, the words *fatal* and *deadly* are conspicuously absent. Clay indicated that the decision to deemphasize the fact that AIDS is a deadly disease was made because although adults are influenced by the idea of potential loss of life from AIDS, the possibility of premature death does not have a significant impact on most youth (James Thalman 1990).

Longshore also suggests emphasizing some of the short-term symptoms of AIDS rather than the long-term consequences (such as death), noting that "previous public-health research indicates that behavior is not greatly affected by low-probability events that occur only in the long term." A brochure that was developed as part of a prevention education campaign in Brooklyn is cited by Longshore as using this approach. It tells teens about "ugly" lesions that often appear on the bodies of people who have AIDS, stressing how such a symptom would negatively affect one's social life.

Trying to change adolescents' behavior through the use of scare tactics will probably have limited success or may in some instances be counterproductive. Adolescents, like all of us, states Basch, use a variety of means to cope with the sense of vulnerability that threatening information may produce. A number of defense mechanisms, including denial, may come into play. When people encounter information as threatening, they may discount the importance of the message, discredit those who convey the message, or seek out others who reject the information. On the other hand, states Basch, some people who hear threatening messages may accept the messages and change their behavior.

The use of humor is mentioned by Longshore as a device that can help to alleviate the anxiety and discomfort that people tend to defend against when sex and death are discussed. As an example of humor being used in relation to HIV/AIDS, Longshore cites a bus poster in San Francisco that addresses the issue of HIV transmission. A portion of the text on the poster reads, "You won't get AIDS from the bus or from the bathrooms, giving blood, shaking hands, parakeets, old sneakers, microwaves or spring cleaning." Skits where actors role play various sexual decision-making scenarios in which issues such as abstinence, delay, and protected sexual intercourse are dealt with can also effectively integrate humor as a way of capturing the audience's interest and relieving audience anxiety by breaking through the taboos associated with discussing sexual matters (Sloane and Sloane).

A Sense of Invulnerability

The strong sense of invulnerability that many adolescents possess may account in part for their tendency to disregard messages about the threat of HIV/AIDS, even though they know how the disease is spread and how to reduce the risk of becoming infected. The belief that "It could never happen to me" is applied to many areas, but is often particularly potent in relation to the idea of dying, where they fail to internalize the risk that HIV/AIDS poses. A sense of invulnerability may explain in part the findings of a study of 38,000 Canadian youth (Alan J. King and others 1989). The study, which surveyed eleven- to twenty-one-year-olds, found that Canadian young people perceive a low probability of being infected by HIV, regardless of their personal behavior.

Dr. Mervyn Silverman, president of the American Foundation for AIDS Research, believes that one way schools can deal with students' sense of invulnerability in regard to HIV/AIDS is by developing an HIV/AIDS curriculum that focuses on areas where students are more likely to believe they can be affected. For example, Silverman points out that while students may not easily relate to the idea that they could die from AIDS, they will be more apt to "pay attention to other effects of the disease like disfigurement, the wasting away of the body and the inability to function or have sex" (Association of California School Administrators 1989b).

One reason teens may feel immune from becoming infected with HIV is related to the virus's unusually long incubation period. Because they are not witnessing their peers getting sick and dying from AIDS, the disease is not very real to them. Asking someone who has AIDS or is HIV positive to come talk to teens may reduce their sense that the disease cannot touch them.

Perception of Reliability of Information Sources

Young people do not consider all sources of HIV/AIDS-related information to be equally reliable. There is some evidence that adolescents tend to be more receptive to information that is presented by peers. In a large Canadian study, medical professionals and school personnel were also regarded by youth as preferred sources of information about AIDS.

Peers

Laura Phillips, who is involved in developing educational programs for the Willamette AIDS Council Youth Program, notes that adolescents believe and take advice more readily from one another than from parents, teachers, or other adults whom they view as authority figures (Thalman 1989).

To facilitate youth-to-youth communication about HIV/AIDS, the Willamette AIDS Council, based in Eugene, Oregon, has put together a youth theater troupe called Youth AIDS Prevention (YAP) that writes and performs skits for peers. The skits promote abstinence as a viable option for teens and encourage condom use among teens who choose to be sexually active. By contacting the Willamette AIDS Council, administrators can arrange to have the YAP theater troupe perform in their school or district.

An awareness of teens' receptiveness to messages conveyed by peers shaped a new AIDS awareness poster campaign aimed at teens. The posters developed by the Willamette AIDS Council are thought to be the first in the nation to use photographs instead of drawings of teens. Rebecca Dravich, a teen who modeled for one of the posters, said she participated in the campaign because she is convinced teens are more apt to listen to one of their peers than to adults. She said, "When it's coming from an adult, it doesn't sound as realistic" (Thalman 1990).

In many schools, students have devoted an issue of the student newspaper to the subject of AIDS. Articles written by peers may carry more weight with teens than stories about AIDS that appear in the adult-controlled media. One high school in San Francisco even sponsored a rap contest about AIDS prevention. Again, teens may be more responsive to messages in the form of lyrics that are created by their peers.

Efforts among teens patterned along the lines of student-organized campaigns against drinking and driving may be effective in helping to change students' behavioral norms in the areas of sexuality and drug use. Social support for behavior change is positively related to altering old behaviors and maintaining new behaviors. A lack of social support for behavior change, on the other hand, can reduce the likelihood that people will choose to change their behavior (Kristine L. Kaemingk and Richard R. Bootzin 1990).

Medical and School Personnel

The Canadian survey mentioned earlier also found that "young people do not regard all sources of information as equally trustworthy." Respondents to the survey said they would prefer to learn about AIDS and other sexually transmitted diseases from medical personnel. In commenting on the survey results, the authors characterized the way young Canadians tend to perceive various information providers:

> They suspect the media of capitalizing on issues like AIDS to sell their products. They think friends are often unreliable, and they believe parents do not know enough about AIDS to advise them. Government-produced material is viewed as watered-down so it will not offend vociferous lobby groups. Conversely, schools and physi-

cians are accepted as reliable sources of information. (King and others 1989)

If American youth feel similarly, it should be encouraging to educators that schools are perceived by young people as trustworthy information providers. This knowledge should also be sobering for school leaders, for it underscores the responsibility educators have to ensure that this confidence in schools as reliable sources of information about HIV/AIDS is well placed.

Perception of Risks versus Benefits in Behavior Change

Hochhauser recommends that people who are developing prevention programs should take into account individuals' sense of risks and benefits. Any contemplated behavior change, states Hochhauser, includes a personal assessment of risks and benefits. He notes that

> Although abstinence, monogamy and condoms may prevent the spread of HIV, individuals may also believe that these methods prevent their ability to be intimate with the person(s) of their choice, to experience their particular kind of sexual pleasure, or to communicate sexually. For some individuals, these values may be more important than the perceived remote risk of contracting AIDS. Prevention programs that fail to take into account such psychological tradeoffs are unlikely to achieve any long term behavioral success.

Because of the role perceived risks and benefits play in decision-making processes and behavioral choices, it is important for educators to grasp what students identify as risks and benefits associated with engaging in or abstaining from behavior that increases their risk of HIV infection.

Developmental Factors

Educational programs intended to reach a specific audience should have an understanding of the characteristics of that audience. Allensworth and Symons also emphasize that "elementary schoolchildren have different developmental values, social reference groups, and physical, psychological, and cognitive needs than their upper grade counterparts."

Summarizing some of the findings of developmental theory, they identify values that tend to guide children and adolescents during different developmental stages. They also note which kinds of influences children and youth are likely to be most responsive to at various ages:

> Five- to seven-year-olds value a sense of duty, accomplishment, and an acceptance of rules. Eight- to 10-year-olds, while experiencing more intense peer influence, take strong cues about acceptable behav-

> ior from adult role models. A transition from parental role model to conformity to rules assigned by peer groups occurs between ages 11 and 13. At this time youth have as a principal role, developing and asserting their own value system in the context of a strong peer influence. While 14- to 16-year-olds need acceptance and security from parents, an intense peer group influence often results in conflict between peer and adult role models. Thus, the abstinence or "just say no" models used in health education in the areas of human sexuality and drug education prove minimally effective in secondary schools. Adolescents often experiment with sex and drugs specifically to rebel against authority figures such as parents, teachers, religious leaders, and police.

McCormick also stresses the need for AIDS education programs to take into account some of the developmental conflicts that face adolescents. She states, "With adolescents and pre-adolescents, HIV programs must be sensitive to the developmental pressure (to have sexual intercourse, to use drugs, and so on), and to their disregard for authority."

An understanding of child and adolescent development can assist those who design and teach HIV/AIDS programs in determining which kinds of messages students will be most receptive to at various ages. Knowledge of developmental stages will also provide educators with a sense of the relative importance of different social groups and values during different periods of development.

Existing developmentally oriented theoretical models that could be potentially useful in HIV/AIDS-related educational efforts have been largely ignored, states Hochhauser. As an example, he cites the work of W.J. McCarthy (1985), who studied the relative importance of physical, social, and psychological health for youth between the ages of nine and nineteen.

According to Hochhauser, McCarthy found that for nine-year-olds, the most important health-related messages were physical, followed by social and psychological messages. For thirteen-year-olds, the most important messages were social, followed by psychological and physical. And for nineteen-year-olds, the most important messages were psychological, followed by social and physical. To be maximally effective, AIDS prevention messages must attend to such developmental differences, especially those associated with cultural and ethnic values.

If one attempts to design or implement an AIDS education program without a thorough understanding of the particular stages of development that children and adolescents undergo, the program will most likely be minimally effective in influencing the behavior of the targeted students.

The factors reviewed above are not an exhaustive accounting of all the variables that affect the extent to which HIV/AIDS information has an impact on the attitudes and behaviors of young people. They do, however,

demonstrate that creating and implementing effective HIV/AIDS education programs is not a simple, straightforward undertaking but one that demands an appreciation of the wide range of factors that influence learning and behavior.

In the following chapter, some general guidelines are offered to provide school leaders with a sense of what kind of information may be most appropriate for students during various periods of development.

Chapter 3

Guidelines for What To Say and When To Say It

As mentioned earlier, it is important for schools to give community members a voice in determining the content of HIV/AIDS education programs, thereby ensuring that the material is consistent with community standards and values. Decisions about what to present to school-age children at different grade levels should be a collaborative effort involving school personnel, medical professionals, parents, and other community leaders. Some authors also recommend that adolescents be given a voice in the curriculum development process. For example, Sloane and Sloane feel that "if teachers and parents approve the curriculum and services, but students do not feel an ownership, and if their needs have not been met, the program will have less of a chance of changing behavior."

Regardless of the composition of the group of people involved in the process of determining the scope of HIV/AIDS education in their communities, this chapter presents some general guidelines concerning children's and adolescents' social, emotional, and intellectual readiness for particular HIV/AIDS-related information.

Health-Related Information

In *The AIDS Crisis: Guidelines for School Districts*, published by the Washington Association of School Administrators (1989), Ann Downer provides some guidelines regarding what to tell children about physiology, health, and disease at various ages:

By the age of five, she recommends that parents should

- give children some general information about where babies come from

- help children learn the names of body parts and their functions
- assist children in making basic distinctions between male and female bodies
- teach children simple health practices, such as washing their hands, covering their mouth when coughing, and staying home when they are ill

Between the ages of six and eight, parents and teachers should

- help children to appreciate that their body is special and private
- teach children about the life cycle, including growth and change, birth and death
- discuss the existence of communicable diseases and chronic illnesses such as measles, colds, flu, cancer

Between the ages of nine and eleven, adults should

- teach children how disease organisms enter the body (through the air, by blood, hand-to-mouth), and discuss how to prevent transmission
- inform children of the emotional and physical changes of puberty and help them to distinguish between physical and emotional readiness for intercourse
- teach children the names and functions of various parts of the reproductive system
- guide children in a discussion of both problems and pleasures associated with the human need for love and belonging

Between the ages of twelve and thirteen, adults should help young people to

- develop decision-making and assertion skills and weigh the consequences of behavioral choices
- understand the structure and function of body systems, including the immune system
- identify transmission and prevention of sexually transmitted diseases
- understand that there are physical, psychological, and sociological aspects of human growth and development
- view human sexuality as a normal part of life
- consider the advantages of avoiding early sexual activity
- identify differences and similarities among the sexual practices of heterosexual, bisexual, and homosexual people
- understand sexual responsibility, including birth control and

condom use

Between the ages of fourteen and seventeen, Downer advises adults to reinforce the material presented above and also help adolescents to

- examine interrelationships among mental health and wellness, communicable and noncommunicable diseases, risk assessment, decision-making, refusal skills, and outcomes of sexual behaviors
- learn how to access personal and community resources

If HIV/AIDS information is placed within a larger health-related context, it is less likely that the information will be misinterpreted or will lead to undesirable outcomes, such as students forming a distorted view of sexuality.

Information about HIV/AIDS

How the topic of AIDS is addressed with students of different grade levels will vary markedly from community to community depending upon a variety of factors. However, some general guidelines may provide those involved in curriculum development and implementation with a place to start when they are in the process of determining what is appropriate for students in their school or district.

Before raising the subject of AIDS, it is a good idea for adults to assess the knowledge and experience of the students they will be talking with. It can be helpful for adults to ask themselves questions such as How old are the children? How much do they already know about HIV infection, AIDS, and other related subjects, such as sex and drug use? Where have they gotten their information and is that information likely to be accurate or inaccurate? Is it likely that the students are sexually active? Is it likely that they use drugs? (National AIDS Information Clearinghouse, n.d.).

And with students of all ages, it is important to emphasize that people who are infected with HIV are in need of compassion and support, just like people who are struggling with any other serious illness. The need to combat AIDS-related prejudice and discrimination is also an area that should be addressed.

Early Elementary School

There are differences of opinion concerning how to approach the subject of AIDS with early elementary school students. In Oregon, where K-3 HIV/AIDS education was mandated beginning in the 1989-90 academic year, many schools are in the process of coming to terms with how much to say to young children about HIV/AIDS.

Foundations for HIV/AIDS: The Preventable Epidemic (Oregon Department of Education 1989), an Oregon curriculum resource guide for grades K-3, identifies three major purposes of prevention efforts at this level: (1) to address children with age appropriate materials in ways that meet their level of understanding, their needs, and their interests; (2) to teach children knowledge, skills, and attitudes that will lay a foundation for practice and reinforcement of lifelong health-related behaviors (including prevention of HIV and AIDS); and (3) to allay their fears concerning transmission of HIV through casual contact. The guide also emphasizes that K-3 instruction, like efforts at higher grade levels, must be both knowledge-based and skill-based.

Is It Too Early? Some people believe that young children today are forced to grow up too quickly and get bombarded with adult-sized worries before their time. In early childhood, they are often exposed to and become concerned about many serious world problems, such as the threat of nuclear war. People holding this view may feel that raising the issue of HIV/AIDS with young children will only rob them of innocence in yet one more area.

In his book *The Hurried Child*, David Elkind (1981) speaks of children who are under "a new pressure to grow up." He defines "hurried children" as children who "are forced to take on the physical, psychological, and social trappings of adulthood before they are prepared to deal with them." He states, "We dress our children in miniature adult costumes . . . , we expose them to gratuitous sex and violence, and we expect them to cope with an increasingly bewildering social environment." Since his book was published before we were aware of AIDS, we can only speculate about how Elkind might view educating young children about AIDS. However, some people may consider HIV/AIDS education in grades K-3 to be another example of how we burden children with problems prematurely.

Emphasis on Reassurance. The CDC recommends that educational efforts directed at young children should be focused on allaying children's fears about AIDS. It may be wise to emphasize the following points when discussing AIDS with younger children:

- AIDS is a disease that is causing some adults to get very sick, but it does not commonly affect children.
- AIDS is very hard to get. You cannot get it just by being near or by touching someone who has it.
- Scientists all over the world are working hard to find a way to stop people from getting AIDS and to cure those who have it. (CDC)

In "AIDS: What Adults Should Know about AIDS (and Shouldn't Discuss with Very Young Children)," Patsy Skeen and Diane Hodson (1987) stress the importance of being conscious of children's developmental levels and cognitive abilities when discussing HIV/AIDS. They also stress that

young children "need a little information and a lot of reassurance." These authors explain:

> The Surgeon General's report does *not* say that 3-, 4-, 5-, 6-, and 7-year-olds, who have as yet little or no concept of sexuality as part of love and family life, little or no concept of life-maintaining blood flowing in their veins, and little or no concept of death, should be given scary information. We do *not* want young children (who, as we all know, muddle the most carefully correct sex information) to get it into their heads that sex will kill you. We do *not* want young children (many of whom fear when they see blood oozing from a small cut that they will deflate like a balloon losing its air and cease to exist) to begin worrying about poisoned blood inside them. We do *not* want young children, for whom it is overridingly important to trust that grownups, most especially parents, will protect them, to be told that babies can be given AIDS through their mothers' blood! Information is not always good. The cognitive context must be considered.

Although Skeen and Hodson believe that the majority of children under the age of eight won't ask "What is AIDS?" and don't have fears about getting AIDS, they acknowledge that some children may verbalize such concerns. Young children who ask direct questions about AIDS should be told that it is a serious disease, but adults should stress that although some people have died from AIDS, it is primarily a disease that adults get and that it is very, very unlikely that the child will contract AIDS.

When children ask questions about things that scare them, Skeen and Hodson remind us that "they essentially want to know that they are safe. They are not seeking an extensive medical education, nor do they expect a discussion of adolescent and adult sexual behavior and drug habits. *To soothe is sufficient.*" If a young child asks how a person gets AIDS, they recommend explaining that it is caused by a tiny germ called a virus.

Talking to Children about Death. Since children already associate AIDS with dying, they may raise questions about death when the subject of AIDS is being talked about. Teachers and parents should be aware that children don't think about death in the same way adults do. Death is an abstract concept that young children will be unable to understand fully because they do not yet have the capacity to engage in abstract thought. Young children usually aren't able to fully comprehend that death is permanent and irreversible. They often believe that people who have died have the ability to come back to life (just as many cartoon characters do).

When talking about death with children, it is best to avoid using analogies or euphemisms because young children, whose thinking processes are concrete, will tend to interpret them literally. For example, if death is compared to going to sleep, children may become afraid of going to sleep, fearing they won't ever wake up.

Verify What Children Have Learned. In discussing any aspect of AIDS, it is important for adults to have children repeat what has been discussed. This will assist adults in determining whether the children have misunderstood any of the material. If so, it can be clarified immediately.

As more and more AIDS-related teaching materials become available, teachers must know how to evaluate them. In assessing potential curricular materials, Skeen and Hodson emphasize that "we must particularly consider how young children will interpret or misinterpret information they are not conceptually ready to hear."

Utilizing Teachable Moments. Jonathan Silin (1990) asserts that young children have heard more about AIDS than adults like to admit. He believes it is best to address the issue more fully in an attempt to clear up children's misconceptions and alleviate the fears that they harbor.

When Silin, who assists New York schools with the process of HIV/AIDS curriculum formulation, asked early elementary teachers in that state what children in their classrooms were saying about AIDS, they indicated that

> AIDS had entered their classrooms through the voices of their students regardless of formal instruction. Ironically, many of these opportunities occurred in elementary classrooms, classrooms in which the prospect of AIDS education seemed most daunting. Sometimes these voices had been heard at the most unexpected moments, sometimes at more predictable occasions. Almost always, teachers had felt unprepared to take advantage of the moment to begin a dialogue that could have led to more structured learning.

In a presentation at the American Educational Research Association earlier this year, Silin shared some elementary teachers' recollections of the ways in which AIDS-related topics had arisen spontaneously among their students. For example, one first-grade teacher told him that when the principal had announced that the subject of the afternoon staff meeting would be about AIDS, "children started accusing each other of having AIDS and warning the teacher not to attend the meeting for fear she might contract it." Another teacher told of children playing tag during recess and designating the person who was "it" as having AIDS. In another case, a second-grade teacher reported that when two baby rabbits failed to thrive, one of her students wondered aloud whether the animals might have AIDS. Still another scenario involved kindergarten children pretending that a toy figure had AIDS and they were rushing him or her to the hospital in an ambulance.

From Silin's perspective, children's fears and misconceptions about AIDS cause the disease to be "a spectre that haunts their movement in the world." Speaking of the need for children's anxiety about AIDS to be replaced with understanding and facts, Silin emphasizes that it is important not

to restrict discussion of AIDS to health classes or science classes, where he feels the topic may be experienced as more distant and less meaningful. He recommends that teachers take advantage of the "teachable moments" that arise when children make spontaneous references to the disease.

When evaluating Silin's perspective on young children's awareness of and anxiety about AIDS, it is important to consider whether children in New York, where the incidence of AIDS is very high, are representative of children in other parts of the country. Because AIDS is more prevalent in New York, it is likely that children in that state are exposed to more AIDS-related information at a younger age than children in other states. Therefore, these children may display a greater degree of anxiety about the disease.

However, regardless of whether the subject comes up rarely or more frequently, teachers should be prepared to address rather than sidestep children's questions and concerns.

Late Elementary/Middle School

There are many differences between older elementary students and adolescents. And adolescents should not be thought of as one homogeneous group. Significant social, emotional, and cognitive differences exist between early, middle, and late adolescence. In addition, an adolescent's chronological age is not always a good indicator of his or her psychosocial maturity. Those presenting HIV/AIDS information should remember that students of the same chronological age may be years apart in their level of psychosocial development. Keeping these things in mind, some of the concepts mentioned by the CDC that should be conveyed to late elementary school and middle school students include the following:

- Viruses are living organisms too small to be seen by the unaided eye.
- Viruses can be transmitted from an infected person to an uninfected person through various means.
- Some viruses cause disease among people.
- Persons who are infected with some viruses that cause disease may not have any signs or symptoms of disease.
- AIDS is caused by a virus that weakens the ability of infected individuals to fight off disease.
- People who have AIDS often develop a rare type of severe pneumonia, a cancer called Kaposi's sarcoma, and certain other diseases that healthy people normally do not get.
- People who are infected are capable of infecting others.
- Every state in the U.S. has reported some cases of AIDS. People

of various ages and racial backgrounds have AIDS.

- The AIDS virus can be transmitted by sexual contact with an infected person, by using needles and other injection equipment that an infected person has used, and can be transmitted from an infected mother to her infant before or during birth.
- It sometimes takes several years after becoming infected with the AIDS virus before symptoms of the disease appear. Because of this, people who do not look or feel sick but are infected with the virus can infect other people.
- The AIDS virus cannot be caught by touching someone who is infected, by being in the same room with an infected person, or by donating blood. (CDC)

Middle School/High School

The following topics are among those the CDC advises educators to consider covering when providing instruction to middle school or high school students:

- The virus that causes AIDS is called HIV.
- The risk of becoming infected can be virtually eliminated by remaining abstinent and by not using IV drugs.
- If two individuals are uninfected and both people have sex only with each other, they cannot become infected with HIV by having sex.
- HIV may be transmitted in any of the following ways:

  a) by sexual contact with an infected person (penis/vagina, penis/rectum, mouth/vagina, mouth/penis, mouth/rectum);

  b) by using needles or other equipment used in injecting drugs that an infected person has used;

  c) from an infected mother to her infant before or during birth.
- Those at increased risk include persons who have unprotected sex, persons who inject illegal drugs, persons who have had numerous sexual partners, persons who received blood clotting products before 1985 (since that time all donated blood has been tested to determine if it is HIV-positive), sexual partners of infected persons, infants born to infected mothers.
- The risk of becoming infected is increased by having a sexual partner who is at high risk of having contracted the AIDS virus (as identified above), practicing sexual behavior that results in the exchange of semen, vaginal secretions, or blood), and using unsterile needles or paraphernalia to inject drugs.
- Although no transmission from deep, open-mouth (i.e., "French")

kissing has been documented, such kissing theoretically could transmit HIV from an infected to an uninfected person through direct exposure of mucous membranes to infected blood or saliva.

- Persons who continue to engage in sexual intercourse with persons who are at increased risk or whose infection status is unknown should use a latex condom to reduce the likelihood of becoming infected. The latex condom must be applied properly and used from start to finish for every sexual act. Although a latex condom does not provide 100 percent protection—because it is possible for the condom to leak, break, or slip off—it provides the best protection for people who do not practice abstinence or maintain a mutually monogamous relationship with an uninfected partner. When used in conjunction with condoms, spermicides that are active against HIV and other STDs can provide additional protection and also reduce the risk of unintended pregnancies.
- Persons who believe they may be infected with the AIDS virus should take precautions not to infect others and seek counseling and antibody testing to determine whether they are infected. (Information about how to obtain counseling and testing for HIV can be obtained by telephoning the AIDS National Hotline at 800-342-2437, the Sexually Transmitted Diseases National Hotline at 800-227-8922, or one's state or local health department.) If persons are not infected, counseling and testing can relieve unnecessary anxiety and reinforce the need to adopt or continue practices that reduce the risk of infection. If persons are infected, they should: a) take precautions to protect sexual partners from becoming infected; b) advise previous and current sexual or drug-use partners to receive counseling and testing; c) take precautions against becoming pregnant; and d) seek medical care and counseling about other medical problems that may result from a weakened immunologic system. (CDC)

When presenting information to a group of adolescents, it is important to be aware that a wide range of sexual knowledge and experience will probably be represented. For example, some students will have already experienced intercourse with same sex or opposite sex partners whereas others may never have kissed anyone. And some adolescents will be involved in dating whereas others will not. Some students may also be justifiably concerned that they could be infected whereas others may harbor unfounded fears based on misconceptions about HIV and how it is transmitted. In addition, some students may have friends or relatives who have AIDS or are HIV positive, whereas to other students the issue of AIDS may seem less personally relevant.

The focus of this chapter has been on what level of AIDS-related information may be most appropriate for students at different ages. As the

preceding chapters stress, however, communicating accurate information about HIV and AIDS is only the first step. In addition to providing medical facts about HIV and AIDS, it is imperative to help students develop or strengthen interpersonal and practical skills that will help them to avoid infection.

Conclusion

Being charged with providing HIV/AIDS education to the current generation of young people is a responsibility that deserves to be taken seriously. The task will not be accomplished easily, but it must be achieved. If the spread of the disease is to be slowed, weaknesses in existing programs need to be remedied in a timely manner. In addition, those providing instruction must be cognizant of factors that influence whether knowledge moves beyond the cognitive level and has an impact on students' attitudes and decisions regarding behaviors that place them at risk. And those who oversee the instruction of others must first put themselves in the position of learners and be willing to learn about their own AIDS-related attitudes, values, and fears.

Responding to AIDS demands that we call upon not only our intellect, but also exercise qualities such as compassion, wisdom, integrity, courage, and creativity. As David L. Kirp (1989) notes, "Everywhere, AIDS poses a threat, less obviously, it offers an opportunity. And all the ways in which we respond to AIDS tell us something of value about ourselves." Like a mirror, issues related to HIV/AIDS—including the quality of instruction we provide to students and how we deal with infected students and staff—will reflect many dimensions of who we are and reveal whether the values we profess are the values we live by. Our ability to deal with the ramifications of the disease on all levels and our attitudes and actions toward those who are infected with HIV will convey a great deal about the quality of our character.

Silin is optimistic that "in the end, the AIDS curriculum will be more about life than about death, more about health than about illness, more about the body politic than the body physical. From AIDS we learn about the limits of science and the importance of human vision, the frailty of the body and strength of the spirit, the need to nurture the imagination even as we direct our attention to rational cognitive structures." Let us give him and ourselves reason to have such confidence by making a commitment to do

what is possible to slow the spread of the disease through education, to respond with compassion and offer support to those who are infected, and to learn and grow from the ways in which AIDS challenges us on both a professional and a personal level.

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